**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

ELITE HEALTHCARE FORT WORTH
PO BOX 1353
FRISCO TX 75034-0023

**Respondent Name**
New Hampshire Insurance Co

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-13-2905-01

**MFDR Date Received**
July 1, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "These bills were previously submitted in a timely mannaer. Please review the sttached documentation and pay according to the TDI guidelines."

**Amount in Dispute:** $349.54

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "…it is the carrier's position that the bill was paid and denied correctly."

**Response Submitted by:** AIG, P.O. Box 25794, Shawnee Mission, KS 66225

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 19 – 25, 2013 | Professional Services | $349.54 | $349.54 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Former 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B12 – Services not documented in patient's medical records.
   - VF09- No significant identifiable evaluation and management service has been documented

**Issues**

1. Did the respondent support the insurance carrier's reason for denying disputed charges?
2. What is the applicable rule for determining reimbursement for the disputed services?

3. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99213 is:

   > Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, **15** minutes are spent face-to-face with the patient and/or family.

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

   - Documentation of the Detailed History
     - History of Present Illness (HPI) consists of one to three elements of the HPI. Documentation found listed three chronic conditions, thus meeting component.
     - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation found listed one system. This component was met.
     - Past Family, and/or Social History (PFSH) are not applicable.
   - Documentation of a Detailed Examination:
     - Requires limited examination of the affected body area. The documentation found examination of four systems: constitutional, musculoskeletal, psychiatric, and skin. This component was met.

   The division concludes that the documentation sufficiently supports the level of service billed.

2. For the reasons stated above, the services in dispute are eligible for payment pursuant to 28 TAC §134.203 (c) as follows:

| Code | Date of Service | MAR Calculation | Units | Allowable |
|---|---|---|---|---|
| 99213 | March 19, 2013 | (55.3 / 34.023) x 71.61 | 1 | $116.39 |
| 97530 | March 19, 2013 | (55.3 / 34.023) x 34.57 | 4 | $224.76 |
| 99213 | March 25, 2013 | (55.3 / 34.023) x 71.61 | 1 | $116.39 |
| | | | Total | $457.34 |

The total allowed for the reviwed services is $457.54. The carrier paid $108.00. The allowed amount less the carrier paid amount leaves a balance of $349.54. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $349.54.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $349.54 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | November 25, 2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.